STATEMENT OF DR. BYRON THAMES

BEFORE THE HEALTH SUBCOMMITTEE

OF THE

HOUSE COMMITTEE ON ENERGY AND COMMERCE

ON

MEDICARE PHYSICIAN PAYMENT

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Mr. Chairman and members of the committee, my name is Byron Thames. I am a physician and a member of AARP's Board of Directors. Thank you for inviting AARP to testify on the important topic of Medicare physician payments.

Over 41 million Americans rely on Medicare for their health insurance. Changes in how Medicare pays physicians have a direct impact on whether we continue to keep this program affordable for beneficiaries.

Unfortunately, recent short-term measures to address the SGR issue have been limited to annual payment increases that simply shift more out-of-pocket costs to beneficiaries without any material improvements in the quality of care they receive. AARP believes there must be a comprehensive approach to Part B payments that not only protects beneficiaries from unreasonable premium and coinsurance increases, but also aligns incentives to encourage high quality care. Medicare and beneficiaries should be getting more for their health care dollar. Tying Medicare's payment to the quality of the care provided is a reasonable way to achieve that goal.

Short Term "Fixes"- No Bargain for Beneficiaries or Medicare

The recent announcement that the 2007 Medicare Part B monthly premium of $93.50 (a 5.6 percent increase from the current $88.50 premium) is lower than originally projected is better than expected. But the calculations for the 2007 premium assume that Medicare physician spending will be cut by 5.1 percent next year as called for under the current payment formula. If Congress acts this year to prevent the physician cut – as many assume – the added cost will further increase the Part B premium. Since the 2007 premium has already been calculated, these increased costs will be rolled into the 2008 – and possibly 2009 – Part B premium. That means that beneficiaries can expect even higher Part B premiums in 2008 and beyond.

The increase in the 2007 premium comes on the heels of a 13.2 percent increase in 2006, a 17.4 percent increase in 2005 and a 13.5 percent increase in 2004. In each year, the premium increase significantly eroded or eliminated the Social Security COLA for beneficiaries with lower or moderate incomes. (See chart 1). These increased costs also erode some of the savings that beneficiaries were to realize from the new Medicare Part D drug coverage

Increased costs to beneficiaries are not limited to premiums. Cost-sharing obligations – which usually reflect 20 percent of Medicare's payment – also jump each time provider reimbursement rates increase.

The impact of the premium and cost-sharing increases cannot be ignored. The average older person already spends about one quarter of his/her income on health care. That does *not* include the additional, and often substantial, costs of services that Medicare does not cover – including long term home and nursing home care. If Part B premiums and cost-sharing continue to escalate, many beneficiaries will find it increasingly difficult to pay for the care they need.

Further, Congress should also recall that every Part B reimbursement increase accelerates the Medicare "trigger". Enacted in the Medicare Modernization Act, the trigger requires Congress to consider potentially harmful cost containment action when the Medicare Trustees project for two consecutive years that general revenues will account for more than 45 percent of total program costs in the next seven program years. Increasing provider payments – without rationalizing the payment system – only contributes to the trigger. (See chart 2).

AARP urges Members of Congress to improve the Part B payment system in a way that protects beneficiaries from unreasonable increases in the Part B premium and coinsurance. This is necessary to ensure that health care does not continue to become increasingly unaffordable for Medicare beneficiaries over time.

Making Medicare a Better Payer of Quality Care

AARP believes that Medicare's Part B payment system should include incentives to promote high quality care. Paying providers to simply *report* quality data may be a necessary first step in this effort, but it cannot be the only step.

Medicare now pays nothing more to recognize those physicians and other providers who give beneficiaries high quality care. Instead, Medicare sometimes pays more to those who provide poor quality care by reimbursing for services that are inefficient or needed to treat the harm resulting from preventable medical errors.

Congressional efforts to address physician payment concerns this year should, at the very least, make payment increases contingent upon reporting of quality data. Eventually, payment updates should be provided to those physicians who meet gradually increasing requirements for both reporting data and demonstrating quality improvements

It simply makes no sense to continue giving providers higher payment rates that are not linked to quality improvement. America already spends more per capita on health care than any other nation, but clearly, we are not getting our money's worth.

Researchers at the Dartmouth Medical School have documented that regions of the United States with the highest health care spending do not have sicker patients or better outcomes than regions with lower spending. They estimate that Medicare could reduce spending by at least 30 percent, while improving the medical care of the most severely ill Americans, if the practices of low-cost, high-quality providers were followed nationwide. A well-structured pay for performance approach could promote the use of those best practices.

The time has come to improve our approach to paying Medicare providers. Offering rewards for high quality, quality improvement, and use of health information technology (HIT) simply makes good business sense.
In the long-run, pay for performance also may help control spiraling health care costs. It could reduce costly errors, avoid unnecessary service duplication, and lessen improper utilization.

Pay for performance might further help temper the tendency to increase the volume of services billed to Medicare following any limits on growth in reimbursement rates. This well-documented volume increase is arguably a greater health threat than the oft-predicted but rarely seen specter of physicians refusing to see Medicare patients if rates do not continue to rise. The Government Accountability Office and MedPAC report that nationwide beneficiaries are not reporting increased difficulties in finding a physician. In fact, the number of services provided, the number of physicians billing Medicare, and the number of physicians accepting Medicare fees as payment in full have all risen.

This volume adjustment phenomenon poses a real health threat because it suggests that Medicare beneficiaries may be receiving many unnecessary services. Increased volume also threatens the financial health of Medicare and of beneficiaries charged coinsurance for unnecessary services. And it is among the reasons why the current physician reimbursement formula, which takes volume into account, repeatedly results in potential pay cuts.

Conclusion

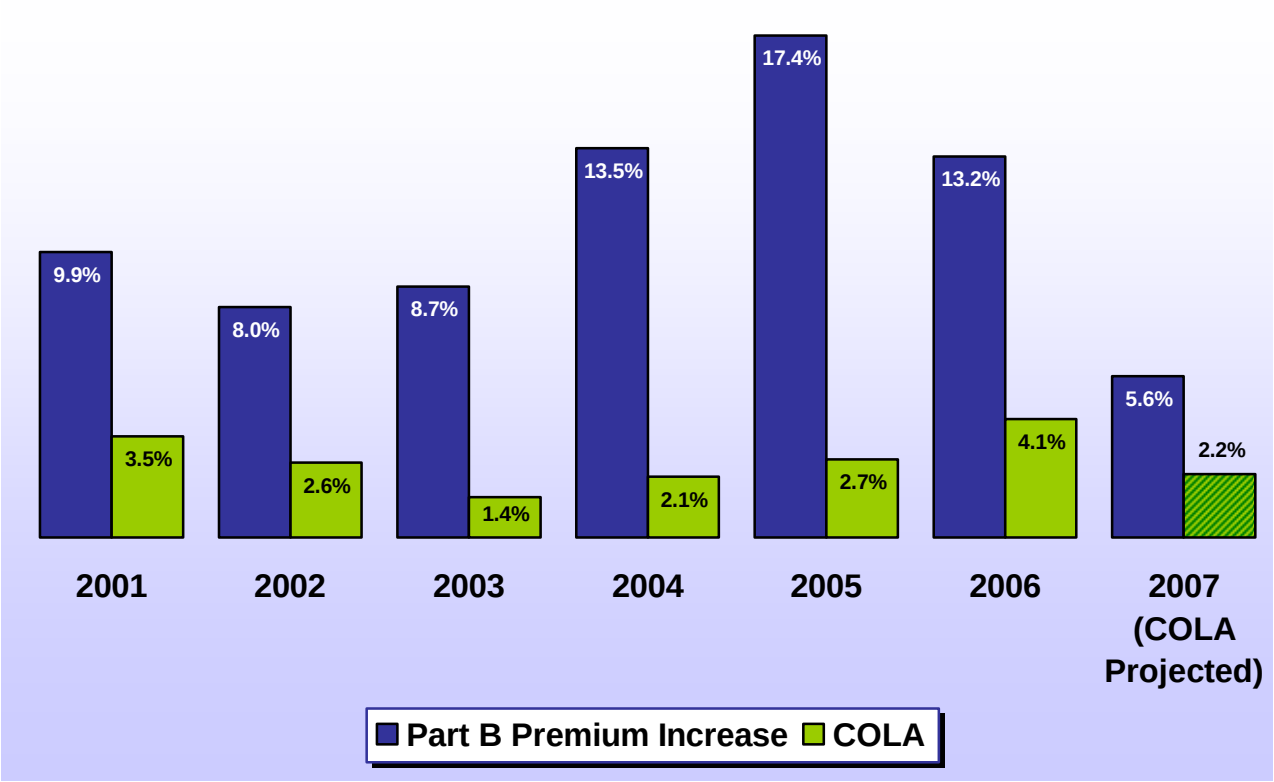
While the repeated threat of physician cuts resulting from the current formula may seem like a crisis, it is in fact an opportunity. Congress should seize this opportunity to forge a truly sustainable Part B payment system by moving towards a pay-for-performance system that realigns payment with high

performance. This new system should also be designed with the beneficiary in mind by holding cost-sharing and premium increases down and improving the quality of care beneficiaries receive.

AARP looks forward to working with Members of the Committee to seize this opportunity and advance quality health care.

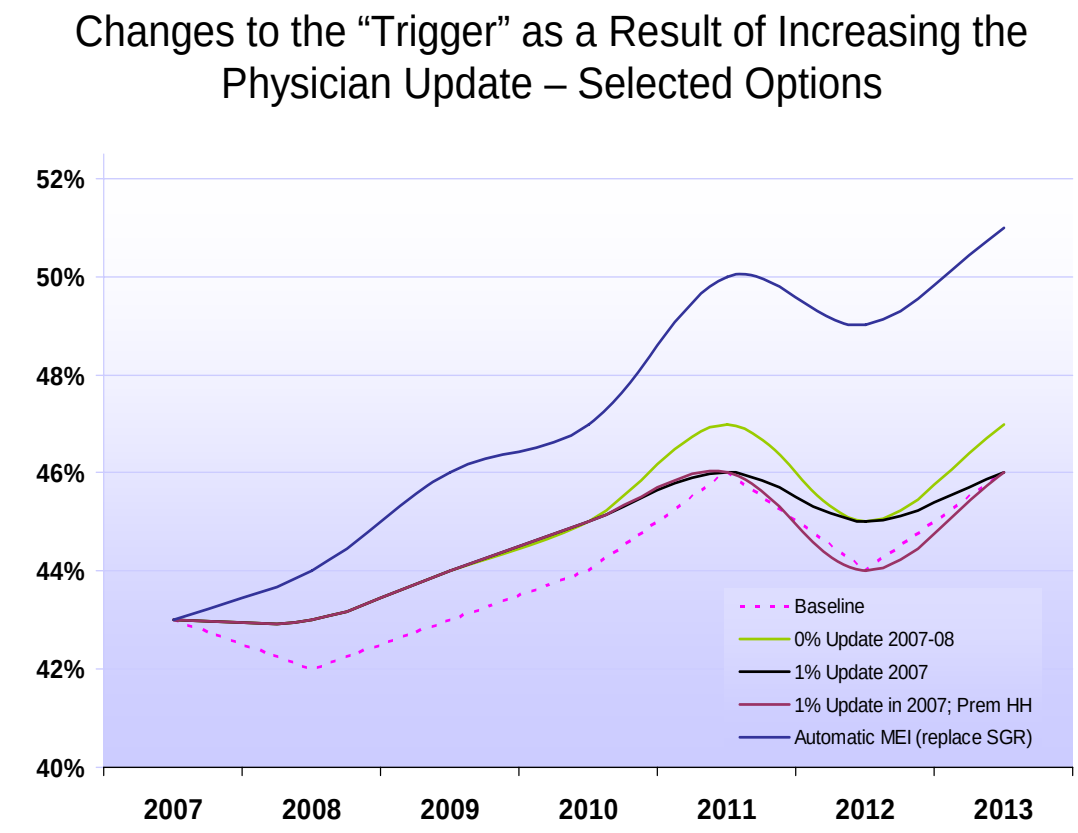
Chart 1

Percent Increase in Part B Premium Dwarfs Social Security Adjustments



Source: Premiums: 2006 Medicare Trustees Report; 2007: CMS Sept. 12 Press Release
COLA: www.ssa.gov/OACT/COLA

Chart 2



Source: AARP Analysis based on CBO Estimates of Changes to the Physician SGR

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